SPECTRUM HEALTH

Authorization RELEASE OF MEDICAL INFORMATION

MEDICAL RECORD NUMBER _____

Patient name _____ Date of birth _____

Maiden name _____

Phone _____ Last 4 digits of Social Security number _____ (optional)

Address _____

City _____ State _____ Zip _____

RECORD RELEASE

I authorize my records to be sent FROM:

Name/Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

I authorize my records to be released TO:

☐ MyHealth Patient Portal _____

☐ Name/Organization _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

INFORMATION REQUESTED

- ☐ Abstract record
- ☐ Consults
- ☐ Discharge summary
- ☐ EEG/ECG/EMG
- ☐ Emergency record
- ☐ History and Physical
- ☐ Immunization record
- ☐ Lab reports
- ☐ Office visit
- ☐ Procedure reports
- ☐ Pathology reports
- ☐ Psychotherapy notes
- ☐ Pathology slides
- ☐ Inspection only
- ☐ Billings, invoices and statements
- ☐ Records related to specific problem of _____
- ☐ Other _____

Date of service(s) _____

RADIOLOGY IMAGES ONLY

Films to be released/From specific dates:

☐ X-ray ☐ Mammography	☐ CT Scan	☐ MRI	☐ Nuclear Medicine ☐ PET/CT	☐ Ultrasound	☐ Interventional Radiology
☐ Images ☐ Reports ☐ Both	☐ Images ☐ Reports ☐ Both	☐ Images ☐ Reports ☐ Both	☐ Images ☐ Reports ☐ Both	☐ Images ☐ Reports ☐ Both	☐ Images ☐ Reports ☐ Both
Dates:	**Dates:**	**Dates:**	**Dates:**	**Dates:**	**Dates:**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

OVER ➔

DO NOT MARK BELOW THIS LINE — BARCODE ZONE — DO NOT MARK BELOW THIS LINE

X01743 (4/19) – Front - (Spanish X13399) (Vietnamese X19128)

* X 0 1 7 4 3 *

PURPOSE OF DISCLOSURE

NOTE: Patient is not required to complete this Purpose Of Disclosure section.

☐ Patient request ☐ Attorney/Legal ☐ Insurance ☐ Continued Patient Care

☐ Other (specify) _____

If you *DO NOT WANT* to release any of your specially protected information in the categories below, check the box(es) for that category:

☐ Information about communicable diseases and serious communicable diseases and infections, as defined by statute and Michigan Department of Public Health Rules, which include venereal disease "VD", tuberculosis, "TB", hepatitis B, human immunodeficiency virus "HIV", HIV test, acquired immunodeficiency syndrome "AIDS", and AIDS related complex "ARC" and _____ (specify other if known).

☐ Alcohol and drug abuse treatment information protected under the regulations in 42 code of Federal Regulations, Part 2.

☐ Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

☐ The release of my DNA test result regarding a diagnosis of _____ (Such as Huntington disease, breast cancer (BRCA1, BRCA2), colon cancer, polycystic kidneys, cystic fibrosis, etc.)

I understand that patient discharge instructions and records from other health care providers may be released with this routine request. I also acknowledge that Spectrum Health assumes no responsibility or liability for the accuracy or legitimacy of any records originating with a non-Spectrum Health provider.

There is potential that information disclosed under the authorization may be disclosed by the recipient and may no longer be protected by Federal Health Insurance Portability and Accountability Act (HIPAA). However, if information under any of the protected categories identified above is released in accordance with this authorization, any re-release of that information may not be allowed under law. This includes the Michigan Mental Health code (sections 748, 749 and 750 of the Public Act 258 of 1974 as amended) and Title 42 of the Code of Federal Regulations, Part II. In that case, the information may not be copied, shared or re-released by the recipient, except as consistent with the stated purpose authorized in this form.

This authorization may be revoked in writing at any time as outlined in the Spectrum Health Joint Notice of Privacy Practices. Spectrum Health does not require this authorization as a condition for giving treatment, payment enrollment or eligibility for benefits.

This authorization will expire sixty (60) days from the date of my signature, unless I specify otherwise

_____

TIME _____ **DATE** _____ Patient or Legal Representative signature _____

Basis of legal authority to act for patient _____

TIME _____ **DATE** _____ _____
Witness

TIME _____ **DATE** _____ _____
Second Witness *(required if patient is unable to sign or gives verbal permission)*

Identification (ID) checked? ☐ Yes ☐ No Driver's license number _____

Copies were: ☐ Mailed ☐ Picked up

H.I.M. to mail? ☐ Yes ☐ No Completed by _____

Send to My Health ☐ Yes ☐ No (print staff name)

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Spectrum Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [81 FR 31465, May 16, 2016; 81 FR 46613, July 18, 2016]

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.844.359.1607 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.844.359.1607. (رقم هاتف الصم والبكم: 711).

